Ending HIV/AIDS Among African Americans in Minnesota

SUMMARY OF COMMUNITY STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS Among African Americans in Minnesota

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St. Paul, MN 55164-0975
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Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

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Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Contents

Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Minnesota HIV Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop.

This is a summary of the facilitated workshop focused on ending HIV/AIDS among African Americans. The workshop was conducted on May 24, 2018, in Minneapolis, Minnesota. A workshop specifically focused on the African American population was held because they are disproportionately impacted by HIV in Minnesota. While African Americans make up only 3 percent of the state's population, they accounted for 27 percent of new HIV infections and 21 percent of people living with HIV/AIDS in 2017. Only 73 percent of newly diagnosed African Americans are linked to care within one month of diagnosis, compared to 88 percent of whites. Compared to other racial/ethnic groups, African Americans have the lowest percentage of viral suppression at 55 percent. This summary also includes findings from a survey that was offered to individuals who were invited to participate in the workshop, but unable to attend.

Participants

Workshop participants

Eighteen people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

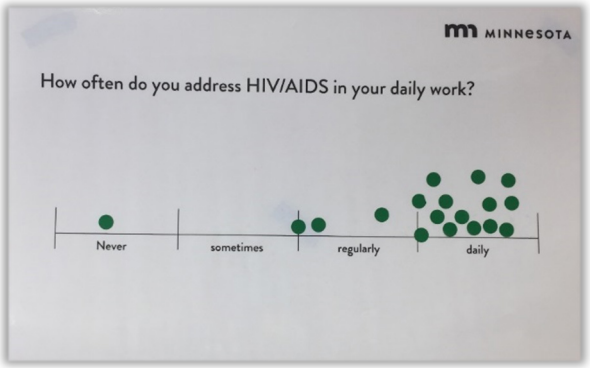
Table 1. Roles of workshop participants

	Workshop participants (N=18)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	5	28%
Chemical dependency provider	0	0%
City or county public health or human services professional	2	11%
HIV services provider	8	22%
Medical provider	1	6%
Mental health provider	1	6%
Social service provider	5	28%
Youth advocate/youth worker	0	0%
Other	3	17%
Unspecified or not pre-registered	3	17%

Note. The number above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" Responses ranged from never to daily, with 14 of the 18 responses being daily.



Survey participants

Nineteen people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=19)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	3	16%
Chemical dependency provider	0	0%
City or county public health or human services professional	3	16%
Faith leader	0	0%
HIV services provider	2	11%
Housing provider	1	5%
Medical provider	0	0%
Mental health provider	0	0%
Social service provider	0	0%
Youth advocate/youth worker	0	0%
Other	3	16%
Prefer not to answer	1	5%
Missing	7	37%

Note. The number above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS among African Americans in Minnesota
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV in the African American population.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the four small groups working together during this workshop, nine strategies were prioritized at least once. These are listed in Table 3. The five strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies from workshop participants

Strategies
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.
Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS among African Americans. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 19)	%
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	7	37%
Strategy 2.2: Engage community leaders, non-profit agencies, people living with HIV (PLWH), and other community members to identify and to address barriers that prevent testing and person-centered care.	7	37%
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	7	37%
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	5	26%

Note. The strategy numbers (e.g., 1.4) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least five people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the five highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The 10 starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ Increase [the number of] providers who offer PrEP/PEP (pre- and post-exposure prophylaxis).* ▪ [Implement] large scale advertising. [Hold] events for normalizing prevention.* ▪ [Integrate] with work on Strategy 5.3 to develop culturally specific interventions. ▪ Organize funding.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ Add HIV to general conversations. Talk openly about it without shame, like talking to people about other health concerns like blood pressure.* ▪ [Increase] awareness about how you respond to different things. ▪ [Increase] understanding of the community, such as why this community is hard to reach and not trusting. ▪ Use your voice, be comfortable, be vocal! If one person stands up, others will listen and follow! Continue cycle of education. ▪ Hold leaders accountable. Call out leaders and vote them out if they are not following through with promises. Use your vote! Show up to meetings and workshops.* ▪ Utilize social media to reach younger populations/generations. Incorporate messages into these forms of media to reduce stigma. ▪ Educate frontline staff! People need to be consciously and culturally aware! ▪ Stop letting white people make decisions for communities they don't engage with.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	▪ [Implement a] culturally specific survey to identify what services are needed and to start a discussion. ▪ [Provide] training and education with health care organizations, AIDS service organizations, and community-based organizations. Use common language. ▪ Hire and train more bilingual staff. ▪ Hire more staff who reflect the community they serve.* ▪ [Create] culture-specific agencies, organizations, referral services.*

Table 5. Brainstormed tactics from workshop participants (continued)

Prioritized strategies	Potential tactics
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	▪ [Provide] flexible funding for rent (e.g., [a] pool of funds).* ▪ [Offer] scattered-site housing, chosen by people living with HIV/AIDS.* ▪ [Ensure that] diverse agencies disperse and receive funding. ▪ [Provide] transportation from housing opportunities in Greater Minnesota.
Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.	▪ Talk with community, church, and political leaders to educate them and learn what is working or is not working.* ▪ Learn from other U.S. states/regions about how to disseminate accurate information and counter misinformation from social media. ▪ Provide resources for organizations to work together to plan social events and educate (not just for World AIDS Day).* ▪ Provide funding to small, appropriate organizations that can't afford grant writers. ▪ [Develop partnerships between] health care providers and organizations like churches to complete rapid testing. ▪ Work with organizations (and schools) to counter misinformation spread on social media.

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	▪ Coordinate between agencies/clinics conducting tests and person-centered care agencies. ▪ Engage providers serving this community. Recruit more providers within the community to serve this community. Build on existing relationships with community groups. ▪ [Locate] services at clinics and doctors' offices to immediately start working with people who are diagnosed. ▪ Use trusted community persons to help connect individuals to care and treatment. Make sure cost concerns are addressed.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ Identify where people of color (POC) congregate (e.g., social establishments, pride events). ▪ [Improve] access to and availability of syringe services. ▪ Have more people that look like and represent the people we are trying to reach out in the communities on a constant basis, not just when there is a need for data. Build relationships that people can trust. Offer incentives, transportation, non-labeled safe places for people to go and be tested or ask questions, etc. Have phone line information available for each targeted population. ▪ Have these services available in prisons, high schools, junior highs, workhouses, job corps, etc. to educate and give services to especially young men and women of color. ▪ Talk to people more in schools to educate and teach them how to take care of themselves better. Have more trained case managers and outreach workers who meet with people one on one.
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.	▪ [Hold] community conversations like you did for continued or ongoing conversation. ▪ [Engage community-based individuals.] I will be repetitive. Just as one person cannot run another person's home effectively, so outside-of-the-community experts cannot address local community and individual needs effectively. ▪ Engage African American leaders to target test their own community. Educate them about how to teach about HIV and then let them educate other folks of color. ▪ [Use] social media for the biggest impact. Those communities that are at higher risk could and would be introduced to information on HIV in their local community. Since it is social media it would be able to be utilized without "outing" someone in public.

Note. The strategy numbers (e.g., 1.3) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least five people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Table 6. Recommended tactics from survey participants (continued)

Prioritized strategies	Recommended tactics
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	▪ Conduct community engagement with populations hardest hit by HIV to learn what they wish the tactic would be to remedy their situation. ▪ Provide face–to-face interactions and phone line assistance. Allocate more funds to areas where the targeted populations live. [Have] full-time outreach efforts within the community with people who look like them. ▪ [Increase] funding. [Use] Medical Assistance billable services. ▪ Have HIV positive individuals speak at various agencies serving people of color. Give free education, condoms, and syringes. ▪ Have a cocktail hour with free drinks to entice people to the location where a presentation can occur. ▪ Talk to people who are receiving public benefits. Education is key.

Note. The strategy numbers (e.g., 1.3) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least five people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS in African-Born Communities in Minnesota

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July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in African-Born Communities in Minnesota

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Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Minnesota HIV Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop.

A workshop specifically focused on the African-born community was held because they experience high HIV rates in Minnesota. The rate of HIV/AIDS among African-born people is more than 13 times greater than the rate among white, non-Hispanic people. This workshop was held on April 26, 2018, at the Minneapolis Urban League in Minneapolis, Minnesota. Nineteen individuals participated. During the beginning of the workshop, several participants expressed major concerns about the workshop's format and structure. These concerns are summarized below:

- Previous community engagement efforts from MDH and DHS were not inclusive of African populations. In particular, participants noted that the Liberian community, one of the largest African populations in Minnesota, was not engaged in the process. In addition, participants pointed out that there is no such thing as one "African-born" community, as each community has its own leadership and communication structures.
- This lack of engagement made it feel as though the Minnesota HIV Strategy was being *done to* the African community, rather than being *done in collaboration with* the community.
- Participants expressed discomfort with repeated requests for information from the community without seeing tangible outcomes or benefits for the community. In particular, participants noted that their communities have had negative experiences with MDH and DHS in this regard.
- Traditional methods of communication from MDH and DHS were ineffective for African-born refugees who cannot read or write, further excluding these portions of the population.
- The HIV Care Continuum data for African-born residents was outdated.

After hearing these concerns, the facilitators decided to deviate from the planned process and capture feedback from participants in a way that was comfortable for them. Ultimately, workshop participants agreed to break into smaller groups to comment on the current Minnesota HIV Strategy and make suggestions to help the Minnesota HIV Strategy better conform to the needs of the African communities that participants represented. In addition, MDH, DHS, and Wilder Research held a follow-up meeting with participants on June 27, 2018 to review what was heard during the initial workshop and invite feedback to ensure their input was accurately captured and described. What follows is a summary of the small group discussions and follow-up meeting.

Small group discussion

During small group conversations, participants provided input about how MDH and DHS could better connect with African populations. Additionally, participants offered comments about the goals and the strategies that are part of the Minnesota HIV Strategy.

Suggestions regarding connecting with African populations

- Create opportunities for authentic engagement with African communities. This begins by acknowledging that these communities are not "one size fits all," and that engagement looks different for different tribes. Suggestions for engagement focused primarily on face-to-face dialogue–rather than email and phone—such as focus groups, making connections through community leaders (tribal leadership, religious leaders, etc.), and attending existing meetings or celebrations. Create and grow true relationships and partnerships with the community.
- Acknowledge that African communities have existing infrastructure (for example, tribal groups, women's groups, youth groups) that can and should be used to do this work, rather than developing new groups or using intermediaries.
- Keep the engagement and momentum going by providing sustainable and ongoing resources (funding and staff time). There had been funding, training, and momentum in the past, but policies and funding shifted away from that, disrupting momentum and awareness of HIV.
- Strategies and tactics should be determined by the African community, as they are one of the populations most heavily impacted by HIV/AIDS. The community should be able to drive the process.
- All strategies and tactics should address social determinants of health, which operate differently in African communities than in American or majority communities. African communities have specific social and cultural contexts that need to be addressed throughout the process. It is important to remember that these contexts vary by tribe, geographic community, etc.
- Create conditions for mutual accountability between the state and communities. Acknowledge that this effort is happening in part because the solutions presented to date have not been effective. Work with communities to establish what accountability looks like for the state and for the community.

Feedback on Minnesota HIV Strategy

Feedback from participants on specific goals and strategies included in the Minnesota HIV Strategy is summarized below. This summary only includes the goals and strategies that were brought up by participants during the workshop.

Goal 1: Prevent new HIV infections

Strategy 1.1: *Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.*

- The focus should be on high-risk populations—list this group first in the wording of strategy 1.1.
- Simplify data for people to understand and communicate easily, particularly if they are not as highly educated or don't know the specialized vocabulary/jargon. For example, instead of saying "50 percent," say "1 of every 2 people in this population are affected." Visualize the data with infographics.
- Employ Africans, both within state agencies and in outside capacities, to do the work as instructors; they can blend these educational activities into existing community events.
- Educate community leaders (including faith leaders) on HIV and HIV resources, and then utilize them and existing structures to deliver educational messages to the community. Support this work with funding.
- Diversify educational strategies like combining community leader engagement with social media and community-specific media outlets to deliver messages.
- Provide training for culturally responsive education. For example, for African women, ask them what culturally specific sex/HIV education should look like.
- Education will look different for different African communities.

Strategy 1.4: *Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.*

- Provide incentives for interventions. For example, provide incentives for every individual tested or provide incentives in more creative ways to save money (raffling, etc.).
- Give resources (particularly funding) to sustain the strategy and the work done in communities.
- Purposefully involve different African communities to lead and do the work for themselves, rather than collecting them into one centralized African organization or entity.
    - Encourage money for implementation within existing initiatives and programming. For example, do not give money for new staff or new rent for a new initiative.
    - Understand that networks already exist within and among African communities—use these networks to do work collaboratively.

Goal 2: Reduce HIV-related health disparities and promote health equity

Strategy 2.2: *Engage community leaders, non-profit agencies, people living with HIV, and other community members to identify and to address barriers that prevent testing and person-centered care.*

- Include and involve faith-based leaders (imams, pastors, etc.), as these leaders are trusted within African communities.
- Support existing structures of leadership and community engagement to find champions within African communities. In addition to faith-based leaders, this includes tribal leaders, women's group leaders, youth group leaders, etc.
- Use grassroots and informal networks to deliver messages as well.

Strategy 2.3: *Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.*

- Clarify that the primary resource needed is funding: African communities in Minnesota have networks and infrastructure with willing staff to carry out the work, but they need adequate funding to do so.
- Focus on sustainability of these resources; provide ongoing support to sustain momentum, not just build it.
- Dedicate these resources directly to community and organizations within the community, not to intermediary organizations who may then subcontract with community organizations. Acknowledge that there is inherited mistrust of mainstream/intermediary organizations due to the disruption of work that was already being done within African communities.
- Provide capacity building and technical assistance for smaller organizations to grow and better qualify for state funding. Allow smaller organizations to focus on the community-based work while, for example, partnering with a larger organization that can handle tasks such as accounting or administrative work.
- Move away from competitive grant-making processes as these are too complex and prohibitive for smaller organizations. Grant-funding models also pose other challenges in their selection and implementation (e.g., needing to have "evidence-based" approaches that may not work in African communities, proposals for funding graded on writing, grant funding runs out). Consider a cohort model of organizations to create a common agenda with MDH/DHS and have mutual accountability.

Strategy 2.4: *Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.*

- Stigma is a major factor/barrier to accessing HIV education, care, and prevention. Addressing stigma is the most important factor in the ongoing work. Create urgency in and by the community to bring the issue into focus and reduce stigma.
- Any tactics to address stigma and structural discrimination/systemic racism need to be culturally responsive and community driven—people will listen to those whom they trust.
- Reduce stigma by integrating HIV services with other health services. For example, by providing HIV testing at a "health fair event" with multiple types of testing (blood pressure, blood sugar, etc.), or by providing access to PrEP at the community pharmacy. In both instances, people are able to avoid outing themselves for "going to the [HIV] clinic" or specifically getting HIV testing.
- African-born residents need different strategies than Africans born in the U.S.; strategies need to address continual influx and learning of new people coming from movement back and forth between the U.S./Minnesota and Africa.
- Address care and prevention for undocumented citizens.
- Address the generational nature of the disparities that exist; this includes educational restrictions on who can do the work (for example, requiring a master's degree for certain positions).

Goal 4: Ensure stable housing for people living with HIV and those at high risk for HIV infection

- Provide subsidies for existing housing (e.g., rent vouchers and transportation supports) so that people can live near their existing communities and where they work; make it a priority to keep families and communities together.

Priorities identified during June 27 follow-up meeting

During the follow-up meeting, MDH, DHS, and Wilder sought recommendations about high-priority next steps as well as guidance on the best way to communicate with African-born community leaders and members about next steps and progress on the Minnesota HIV Strategy. Those recommendations are listed below.

High-priority next steps

- Prioritize providing funding and other support to African communities that have the highest incidence and prevalence of HIV here in Minnesota.
- Prioritize reaching out to the "gatekeepers" or champions within the community, such as faith-based leaders and formal and informal group leaders who are committed to their communities and the work of ending HIV/AIDS.
- Prioritize community education with simplified data, working with and providing training and funding support to the community to do this.
- Prioritize providing organizations and leaders within the community with ongoing support and capacity building in order to promote sustainability. Organizations and leaders within the community should be charged with leading the work of ending HIV/AIDS within their community.
- Prioritize working with community to build an idea of what success in this work looks like within the community. Do this instead of imposing benchmarks or guidelines of what success looks like from the state/institutional perspective.

How to communicate with African communities, and vice versa

- Participants expressed a specific desire for this communication to be bi-directional. MDH and DHS should not just communicate with communities, but communities should be able to initiate contact and communication with the state as well. Ensure that there is mutual accountability.
- Begin by bringing leaders from the most impacted African communities and state staff together for face-to-face dialogue.
- Ensure continuity across contact and engagement; in the words of one participant, "It needs to be a continued, ongoing relationship. We can't just jump in and jump out."

Web survey input

In addition to the facilitated workshop, a web-based survey was offered so that individuals who were unable to participate in the workshop were able to contribute their input. The survey asked respondents to identify the three strategies that they feel are most important for the African-born population, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it.

Eleven people provided input via the survey. Table 1 shows survey participants' roles or areas of work. Participants could select multiple roles or areas of work.

Table 1. Roles of survey participants

	Survey participants (N=11)	
Role or area of work	N	%
Advocate for, or member of, high-risk population[a]	2	18%
Chemical dependency provider	0	0%
City or county public health or human services professional	1	9%
Faith leader	1	9%
HIV services provider	1	9%
Housing provider	1	9%
Medical provider	2	18%
Mental health provider	0	0%
Social service provider	0	0%
Youth advocate/youth worker	0	0%
Other	2	18%
Prefer not to answer	1	9%
Missing	1	9%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS in the African-born population. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 2.

Table 2. Prioritized strategies from survey participants

Strategy	N (out of 11)	%
Strategy 2.2: Engage community leaders, non-profit agencies, people living with HIV (PLWH), and other community members to identify and to address barriers that prevent testing and person-centered care.	6	55%
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	6	55%
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	4	27%

Note. The strategy numbers (e.g., 2.2) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least four people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 3 lists the tactics that they recommended.

Table 3. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.	▪ [Engage] community health workers (CHW) and Minnesota Local Public Health Association (MLPHA) [in] conversations with leaders. ▪ [Provide] training on basic HIV/AIDS issues and stigma to community leaders, religious leaders, and other leaders. They should know how to respond to an HIV/AIDS problem when it arises in their community and be able to counsel, refer, and connect [community members] with service providing organizations. ▪ Give them the skills to advocate and ask for [what they] want [and] need; listen. ▪ [Engage community-based individuals.] Just as one person cannot run another person's home effectively, so outside-of-the-community experts cannot address local community and individual needs effectively.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ [Engage] individuals who know the African-born cultures. ▪ [Produce] more media about the changes in HIV. People are still stuck in the 1980s about transmission. [There are] patients [who] refuse to set up local primary care because they believe they will experience discrimination. [Provide] education on professional confidential laws. Educate the population about the importance of primary care. ▪ Education.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	▪ [Provide] more community resources for those with Anuak language for meeting basic needs such as county services. Anuak interpreters are difficult to find, and language is very important for medical care. ▪ [Make] health navigators available to newly diagnosed patients. ▪ Speak to functional African-born HIV/AIDS related agencies in Minnesota. ▪ Provide cultural sensitivity training to staff (including front desk folks, janitorial staff, and even executive directors).

Note. The strategy numbers (e.g., 2.2) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least four people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS in Central Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in Central Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

Contents

Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Minnesota HIV Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop, and offered a web survey to individuals who were unable to participate in the workshop.

To ensure geographic representation across Minnesota in this process, feedback was sought through workshops and web surveys in each of eight regions of the state. This is a summary of the facilitated workshop focused on ending HIV/AIDS in the central region. The workshop was conducted on May 22, 2018, in St. Cloud, Minnesota. This summary also includes findings from the web survey respondents.

Participants

Workshop participants

Fifteen people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

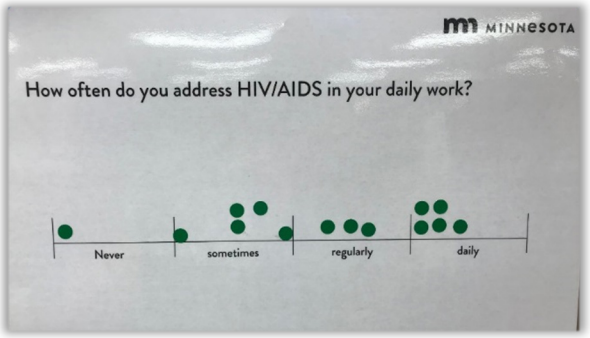
Table 1. Roles of workshop participants

	Workshop participants (N=15)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	4	27%
Chemical dependency provider	2	13%
City or county public health or human services professional	6	40%
HIV services provider	3	20%
Medical provider	3	20%
Mental health provider	2	13%
Social service provider	2	13%
Youth advocate/youth worker	0	0%
Other	4	27%
Unspecified or not pre-registered	0	0%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" The 14 responses ranged from never to daily.



Survey participants

Thirteen people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=13)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	0	0%
Chemical dependency provider	0	0%
City or county public health or human services professional	3	23%
Faith leader	0	0%
HIV services provider	0	0%
Housing provider	0	0%
Medical provider	1	8%
Mental health provider	2	15%
Social service provider	1	8%
Youth advocate/youth worker	0	0%
Other	1	8%
Prefer not to answer	1	8%
Missing	4	31%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS in the central region
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV in the central region.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the four small groups working together during this workshop, 10 strategies were prioritized at least once. These are listed in Table 3. The three strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies from workshop participants

Strategies
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.
Strategy 5.5: Create effective information sharing partnerships and systems that produce reliable data and that inform decision-making, strategy development, and program accountability.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS in the central region. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 13)	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	4	31%
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	7	54%
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.	7	54%
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	6	46%
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.	4	31%

Note. The strategy numbers (e.g., 1.3) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least four people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the three highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The six starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Utilize public health as one platform to distribute information. ▪ Educate health providers on minor consent law. ▪ Advocate for changes in state education policies around sex education. Incentivize comprehensive sex education instead of abstinence-only.* ▪ Teach bedside manner to physicians. ▪ Normalize testing. Offer programs or seminars for medical professionals about questions they should be asking during a medical visit. Centers for Disease Control (CDC) has recommendations around sexual health. ▪ [Create] visibility - more advertisements, more billboards, advertisements on buses. There are so many advertisements about everything else, why not more about HIV (e.g., from MDH for testing)?* ▪ [Provide] incentives to get tested. ▪ Figure out how insurance companies decide what people should be tested for and how often, and get it changed. ▪ Get CDC involved in providing a formal recommendation that HIV testing happen annually and increasing education among providers about what they should be doing.

Table 5. Brainstormed tactics from workshop participants (continued)

Prioritized strategies	Potential tactics
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ Identify culturally sensitive providers. The State should reach out to them to provide technical assistance around Minnesota's AIDS Drug Assistance Program (Program HH) and billing as well as to provide education (i.e., provider resources). ▪ Create provider directory/network that is maintained and updated (make lists localized for each area/region). ▪ Set minimum benefits for mental health and substance abuse. [Ensure they are] provided, seamless, and uniform.* ▪ Explore ways to allow consistency with case management services/case workers for individuals [to help] build relationships and trust. ▪ [Host] regular provider network meetings to share information and identify gaps. ▪ [Provide] trauma-informed care training for providers. ▪ Look at increasing reimbursement rates for psychiatry, mental health services, and health rehabilitation services. Revenue does not cover cost and there have not been increases in many years. Dental [reimbursement] is also very low. This can lead to lower quality services and lower availability. ▪ [Have] navigators (health, basic needs, etc.) for persons living with HIV while using a person-centered approach. This person can address individual needs and connect them to appropriate services.*
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	▪ [Offer] routine testing for new immigrants/students/visa holders in Minnesota.* ▪ Talk to insurance companies about making HIV testing confidential on Explanation of Benefits (EOB) (i.e., don't explicitly list HIV testing on EOB so parents/policy holders can't identify tests conducted). ▪ Create a regional HIV coordinator [position] and have state link reported cases to regional HIV coordinator. This would be a resource for patients and providers--one HIV contact number for each region.* ▪ Investigate data about characteristics of people who are not linked to care within 30 days.

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ [Improve] HIV education and awareness in public schools. It has slipped [and needs to] at least get back to where we were 20+ years ago. We could potentially replicate some of the awareness campaigns of the past. ▪ Require specific trainings for health professionals. [Have] an outreach program for students and high-risk populations. [Implement] marketing strategies utilizing media to get the information to all individuals. ▪ [Have] training, education materials, and tools for agencies to help educate employees.
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	▪ Let clinics know where to refer patients by providing regularly updated information. There are online resources, but at the clinic level, we need easy and immediate access for patients and staff. ▪ Have a task force that has resources available in one spot so any health professional can click on a link, get answers, send referrals, etc. ▪ Connect people living with HIV to a provider that has experience in treating HIV and connect them to Rural AIDS Action Network for additional support.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ Engage CentraCare in assisting with this work. Educate providers in evidence-based interventions and prevention strategies. Assist public health agencies in accessing funding for evidence-based programs such as syringe services. Help reduce the stigma in central Minnesota. None of this will happen until people can talk about HIV. ▪ [Provide] low- to no-cost transportation to the client and easy availability.
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.	▪ Do not gut the ACA - address this with lawmakers.
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	▪ Include those that are hardest hit in advisory group capacities.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least four people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Additional participant contributions

Workshop participants shared several additional comments throughout the process that are listed below.

- It is important to find the 1,100 people [estimated by the state epidemiology data] who are living with undiagnosed HIV.
- A few things were missing from the Strategy.
  - Strategy 1.3 is missing the notion that newly diagnosed people need to be linked to mental health resources (support groups) and social services. People get a lot of information at once and might not be mentally ready to take everything in.
  - Goal 3 should acknowledge a need for judgement free health care. We need to normalize sexual health, because it is still taboo to talk about sexual health. Open, frank conversations do not happen as much with providers, they are more common to have in college health clinics.
  - Strategy 5.2 should involve the Department of Commerce because they regulate the private health care market.
- We need to normalize HIV testing. There is no need for opt-out testing anymore (except for cost reasons). Everyone should be tested. We should offer STI testing and HIV testing as if it should be something everyone should do.
- Data about income bracket would be useful; it may be higher income individuals that are infected. They may not be as connected to social services and this may explain some of the percentage of individuals who are not connected to care (17%).
- Due to abstinence-only funding for schools, some counties, such as Wright County Public Health, teach sex education because schools cannot.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS in the Latino Population in Minnesota

SUMMARY OF COMMUNITY STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in the Latino Population in Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Contents

Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Minnesota HIV Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop.

This is a summary of the facilitated workshop focused on ending HIV/AIDS in the Latino population. A workshop specifically focused on the Latino population was held because Latinos/Latinas are disproportionately impacted by HIV in Minnesota. While Latinos/Latinas make up 5 percent of the state's population, they accounted for 12 percent of new HIV infections and 10 percent of people living with HIV in 2017. The workshop was conducted on May 10, 2018, in Saint Paul, Minnesota. This summary also includes findings from a survey that was offered to individuals who were invited to participate in the workshop, but unable to attend.

Participants

Workshop participants

Thirteen people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

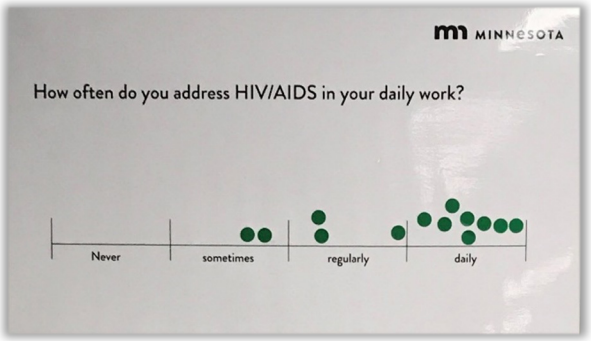
Table 1. Roles of workshop participants

	Workshop participants (N=13)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	3	23%
Chemical dependency provider	0	0%
City or county public health or human services professional	3	23%
HIV services provider	8	62%
Medical provider	0	0%
Mental health provider	0	0%
Social service provider	2	15%
Youth advocate/youth worker	1	8%
Other	2	15%
Unspecified or not pre-registered	2	15%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" Responses ranged from sometimes to daily, with 8 of the 13 responses being daily.



Survey participants

Five people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=5)
Role or area of work	N
Advocate for, or member of, high-risk population[a]	1
Chemical dependency provider	0
City or county public health or human services professional	1
Faith leader	0
HIV services provider	0
Housing provider	0
Medical provider	2
Mental health provider	0
Social service provider	1
Youth advocate/youth worker	1
Other	1
Prefer not to answer	1
Missing	0

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS in the Latino population in Minnesota
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV in the Latino population.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the four small groups working together during this workshop, 10 strategies were prioritized at least once. These are listed in Table 3. The four strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies from workshop participants

Strategies
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.
Strategy 4.3: Ensure that people living with HIV (PLWH) and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.
Strategy 5.1: Create a leadership structure that is held accountable for implementing and updating this strategy. This leadership structure will include key stakeholders that this strategy affects, such as government leadership, community-based organizations, PLWH, and Minnesota residents that the HIV epidemic hits hardest.
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS in the Latino population. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 5)
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.	3
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	2
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.	2

Note. The strategy numbers (e.g., 1.4) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least two people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the four highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The eight starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Identify new community partners. ▪ Teach [organizations] how to write grants and how to disperse grant funding that is more equitable. ▪ Mandate [at the] state [level] and support the schools by dedicating resources to assist with providing k-12 sexual health education. ▪ Educate at each level of care to deliver the same messages to population served through languages that are culturally appropriate. ▪ [Develop a] public campaign and marketing strategies to address populations hardest hit by HIV. Multiple, but targeted messages and billboards that are culturally appropriate within communities. ▪ [Develop] language and education targeted to meet people's needs regardless of age or culture over the lifespan.* ▪ Actively participate in community events to make our presence known. Groups and active programs that provide services for culturally specific individuals. ▪ [Engage in] open discussions and education with community-based organizations/grantees by DHS, Hennepin County, and MDH. Allow for flexibility with funding and room to collaborate to create best practices as a collective group to really meet the needs of Latino, men who have sex with men (MSM), injection drug users (IDU), and LGBTQ people affected by HIV/AIDS. New partnerships and equitable disbursement of funding. Innovative partnerships to create a new approach to serving the needs [of the community]. Educate grantmakers and grantseekers with the shared vision of creating adequate/equitable/innovative sexual health partnerships and programming.*
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ Engage community and recruit members of community. ▪ Utilize media platform. ▪ Include people in service delivery. "Nothing about us without us." * ▪ Create community ambassadors. ▪ Take down systems, shift cultural norms, address white folks--white people need to hold others accountable. "Dear White People."* ▪ [Conduct] culturally specific assessments, figure out what stigma looks like in each culture. Stigma varies across multicultural difference. ▪ Educate voters--who are you voting for?

Table 5. Brainstormed tactics from workshop participants (continued)

Prioritized strategies	Potential tactics
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	▪ [Provide a] peer to peer support group that addresses mental health and substance abuse. Should be bilingual and have translation (have medical interpreter specialized in HIV education). Also use this space as a "focus group" as a way to hear from PLWH about what barriers they face. Have a built in feedback loop. ▪ Provide more formalized training for interpreters on HIV, and more training on HIV across the board. In conjunction with training on HIV, have education for the community and the providers on respecting transgender and LGBTQ community (lots of stigma in the Hispanic community - the biggest issue is with elders and newcomers to the country).* ▪ Train providers on culturally specific knowledge. ▪ [Have] trauma-related community discussion. Good food, good music, right place - have trauma related discussion all together with all races. ▪ [Provide] trainings for community on trauma. Culturally specific education and resources on talking about trauma. ▪ [Provide] funds for transportation. Taxis/staff able to provide a ride to support access to care. Not a bus - on weekends they are not consistent and will cancel. ▪ Build a network to share information - a holistic approach across organizations to provide information on resources like housing, mental health, chemical dependency, eating habits, etc. Share learning across cultural communities.*
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.	▪ [Provide] telemedicine for HIV care and PrEP (can be bilingual).* ▪ Use local public health more to integrate HIV policy. Needs to include education to Community Health Boards. ▪ [Develop] targeted web-based outreach to Latino MSM with incentives for testing.* ▪ Facilitate clinics that serve Latino community to become more HIV and STD competent--especially in rural Minnesota. Tele-medicine can also be used to train providers. ▪ [Provide] state government (MDH, DHS, Hennepin County) funding sources that are more coordinated and clear. Very interwoven, but chaotic now. ▪ Establish a state medical consultant for HIV (like the state TB consultant). Can be a resource for providers to become skilled and comfortable.

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ [Provide] syringe service options. [Add] more community options for testing and treatment [and] more community providers. ▪ [Have] community HIV testing [provided] by Latin health advocates.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ Offer community education and [create] media campaigns that address HIV stigma. ▪ [Have] HIV information including medication, appointments, and insurance information available in Spanish.
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.	▪ Increase Community Health Worker (CHW) and Public Health Nurse (PHN) staffing for outreach, education, testing opportunities.

Note. The strategy numbers (e.g., 1.4) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least two people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Additional participant contributions

Workshop participants shared additional input throughout the facilitated activities. This input is described below.

- Participants provided feedback about elements of the Minnesota HIV Strategy.
- Participants expressed that strategy 2.4, specifically the part about systemic racism, can be seen in all aspects of this work. They noted that it interacts with all other strategies and is imbedded in our system and everyday work. They also noted that it should be at the front of the Minnesota HIV Strategy because it is such a big issue to tackle.
- Participants noted that, in relation to strategy 1.1, visibility is a big issue. They said that it would have been great if CLUES opened a clinic within the community on Lake Street, but this requires money.
- Strategies 3.1 and 3.2 stood out, especially because only 57 percent of Latino PLWH are virally suppressed. They noted that it was really important to keep people retained in care and get them virally suppressed.
- Latino community members living in Dakota County tend to seek services at La Clinica (located in Ramsey County), but that's the only option. This is not enough for people who are undocumented.
- Participants highlighted the specific stigma in the Latino community around being HIV-positive and gay.
- Participants noted that people without basic education are more difficult to get connected to care. They noted that there aren’t public campaigns about HIV, particularly in Spanish.
- Participants expressed overall concern about erosion of funding for sexual health education (both at national and state levels). They noted that this affects all communities.
- Participants recommended that MDH, DHS, and Hennepin County educate their grantees before awarding funds to ensure understanding of service commitment.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS Among Men of Color Who Have Sex With Men in Minnesota

SUMMARY OF COMMUNITY STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS Among Men of Color Who Have Sex With Men in Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Contents

Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Minnesota HIV Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop.

This is a summary of the facilitated workshop focused on ending HIV/AIDS among men of color who have sex with men (MSM of color). A workshop specifically focused on MSM of color was held because MSM of color have lower viral suppression than white MSM. African American and Native American MSM have the lowest viral suppression at 54 percent and 56 percent, respectively. Native American, African American, and Asian/Pacific Islander MSM have the highest percentages of being out of care at 31, 35, and 36 percent, respectively. The workshop was conducted on May 3, 2018, in Minneapolis, Minnesota. This summary also includes findings from a survey that was offered to individuals who were invited to participate in the workshop, but unable to attend.

Participants

Workshop participants

Ten people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

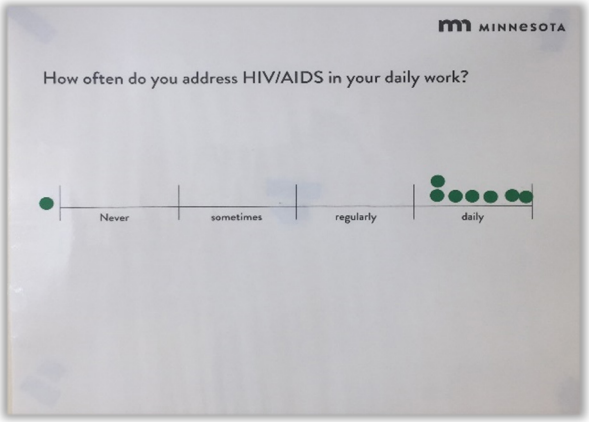
Table 1. Roles of workshop participants

	Workshop participants (N=10)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	3	30%
Chemical dependency provider	0	0%
City or county public health or human services professional	1	10%
HIV services provider	3	30%
Medical provider	0	0%
Mental health provider	1	10%
Social service provider	3	30%
Youth advocate/youth worker	0	0%
Other	3	30%
Unspecified or not pre-registered	2	20%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" Responses ranged from never to daily, with 7 of the 8 responses being daily.



Survey participants

Six people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=6)
Role or area of work	**N**
Advocate for, or member of, high-risk population[a]	1
Chemical dependency provider	0
City or county public health or human services professional	1
Faith leader	0
HIV services provider	2
Housing provider	0
Medical provider	0
Mental health provider	0
Social service provider	0
Youth advocate/youth worker	0
Other	1
Prefer not to answer	1
Missing	1

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS among men of color who have sex with men in Minnesota
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV among men of color who have sex with men.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the two small groups working together during this workshop, seven strategies were prioritized at least once. These are listed in table 3. The two strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies from workshop participants

Strategies
Strategy 2.2: Engage community leaders, non-profit agencies, people living with HIV (PLWH), and other community members to identify and to address barriers that prevent testing and person-centered care.
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.
Strategy 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.

Note. The strategy numbers (e.g., 2.2) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS among men of color who have sex with men. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 6)
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	4
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.	2
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	2
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	2

Note. The strategy numbers (e.g., 2.4) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least two people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the two highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The four starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ [Form a] Community Advisory Committee.* ▪ Train from the top down. ▪ [Provide] diverse representation for [grant application] reviewers.* ▪ Chang the definition of success.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	▪ Provide testing to people where they feel comfortable and safe (in their homes, on the street, etc.). ▪ [Recruit] decision makers from the community so they have context for the experience of the people they serve. ▪ [Provide] funding that focuses broadly on men--we can get rid of a lot of the labels and this will help us reach a broader community.* ▪ Encourage and support people of color and men who have similar sexual experiences to assume positions of leadership. ▪ [Work with] church outreach programs. Men of color talking about sex with men with church leaders and community representation.*

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ Get Medicaid and other health plans to reimburse for the medications involved without barriers or challenges. Currently, it is very difficult to get health plans to cover PrEP without prior authorization and excessive advocacy.
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	▪ [Conduct] outreach [with] culturally specific staff [who are] embedded in the communities that are not receiving the same services or lack the education to know about the services.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ [Increase] education/engagement/awareness! ▪ Require racial equity training for large organizations doing this work.
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	▪ Integrate HIV related services (syringe exchange, testing, condoms, sex education) into all health care facilities. Everyone deserves access to condoms, testing, and clean syringes at the very least.

Note. The strategy numbers (e.g., 1.4) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least two people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS in Northeast Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in Northeast Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Contents

Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop, and offered a web survey to individuals who were unable to participate in the workshop.

To ensure geographic representation across Minnesota in this process, feedback was sought through workshops and web surveys in each of eight regions of the state. This is a summary of the facilitated workshop focused on ending HIV/AIDS in the northeast region. The workshop was conducted on May 7, 2018, in Duluth, Minnesota. This summary also includes findings from the web survey respondents.

Participants

Workshop participants

Twenty-one people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

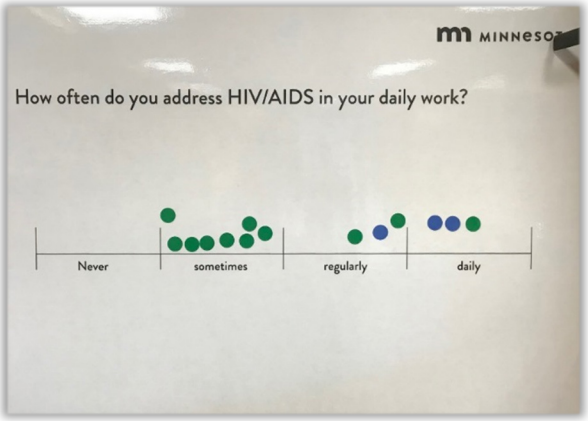
Table 1. Roles of workshop participants

	Workshop participants (N=21)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	3	14%
Chemical dependency provider	0	0%
City or county public health or human services professional	9	43%
HIV services provider	4	19%
Medical provider	2	10%
Mental health provider	2	10%
Social service provider	4	19%
Youth advocate/youth worker	2	10%
Other	4	19%
Unspecified or not pre-registered	1	5%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" Responses ranged from sometimes to daily, with 8 of the 14 responses being sometimes.



Survey participants

Ten people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=10)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	1	10%
Chemical dependency provider	0	0%
City or county public health or human services professional	2	20%
Faith leader	1	10%
HIV services provider	0	0%
Housing provider	1	10%
Medical provider	0	0%
Mental health provider	0	0%
Social service provider	2	20%
Youth advocate/youth worker	1	10%
Other	1	10%
Prefer not to answer	0	0%
Missing	5	50%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS in the northeast region
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV in the northeast region.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the four small groups working together during this workshop, nine strategies were prioritized at least once. These are listed in table 3. The four strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies from workshop participants

Strategies
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.
Strategy 3.5: Ensure access to services that meet the basic needs of people living with HIV (PLWH).
Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS in the northeast region. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 10)	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	4	40%
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	4	40%
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	4	40%
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.	3	30%
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	3	30%
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	3	30%

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least three people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the four highest priority strategies highlighted in table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The six starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Talk about available services at University of Minnesota-Duluth (UMD) Bull Dog welcome week orientations. ▪ Develop statewide school standards for sex education and put into mandate through Board of Education. Health people develop and education people implement. Require at all levels and have specific guidelines for levels.* ▪ Develop a succinct messaging campaign (including ideas on ongoing danger, hope, and treatment) that is in all sorts of materials (social media, print, messages, etc.). Go beyond HIV, include all sexually transmitted diseases (STDs).* ▪ Research and talk with organizations beyond grand rounds. Table out incentives for providers to move time in their day to attend. ▪ Have the Minnesota Department of Health (MDH) be a continuing medication education (CME) provider or coordinate with organizations for CMEs. Make learning about HIV through CMEs a requirement. ▪ Connect with medical residency programs. Re-emphasize training for sexually transmitted infections (STDs) section on boards. Contact curriculum development bodies to see what is being taught. ▪ Educate providers. Essentia should be at the table. Providers are the in-roads for message delivery. Have conversations about messaging and reaching rural populations. Connect/collaborate with Office of Rural Heath, UMN, MN Association for Rural Health, Wilderness Health. Educate and talk with health care organizations serving teens. Use temporary doctors, traveling doctors and nurses, and transportation vans. Possibly begin this tactic with a one-day summit. ▪ Target campaigns at jails, homeless shelters (e.g., Union Gospel Mission, CHUM, Lighthouse), churches, Salvation Army, and food shelves. Include information pamphlets delivered with food or other services. Have community conversations with community leaders. ▪ [Conduct] additional research on Hepatitis C and other comorbidities. These are more prevalent and could be a good place to get more data to identify populations that could be high-risk. ▪ Connect with dental providers, mental health [providers], treatment [providers], etc. ▪ Get walk-in clinics in rural areas.

Table 5. Brainstormed tactics from workshop participants (continued)

Prioritized strategies	Potential tactics
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ Educate providers (including physicians' assistants, medical doctors, registered nurses) on PrEP reporting services. ▪ [Create a] mobile regional HIV coordinator.* ▪ [Provide] mobile units for syringe exchange, PrEP, testing, and beyond.* ▪ Include law enforcement and emergency medical services for buy in. ▪ Incentives for people who test and testing events (could be combined with Hepatitis C events). ▪ Routine testing for medical personnel.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	▪ Educate medical professionals on issues [faced by LGBT people and people of color] so people can see a doctor and get tested without having to educate our providers. ▪ Move beyond the 101 and box checking for training. ▪ Do tracking around micro aggressions.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	▪ Advocate for changes in policy.* ▪ Obtain long-term funding for established programs and services.* ▪ Turn empty buildings into affordable housing with supportive services in the buildings. ▪ Turn empty houses into affordable housing. ▪ Coordinate among social services to avoid competition for funding. ▪ [Develop] a funding stream that avoids competition between social agencies. ▪ [Provide] services for youth before they get evicted rather than after. Preventive versus triage.

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Educate students and high-risk populations about transmission and the importance of being tested and treated if engaged in risky behaviors. ▪ [Provide] strategies for making wise choices like abstinence or one partner. [Do so in] health classes, gym classes, biology classes, homeless shelters, gyms, YMCAs, bars, community events. ▪ Have a messaging campaign that is consistent and applicable across the population.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ None provided
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.	▪ Do not make this just HIV specific. This should be general public policy to maximize health equity.
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	▪ Connect with organizations that are representative of and responsive to populations of color.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ None provided
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	▪ Put public monies into affordable housing and relationship education. ▪ Educate everyone, but particularly policy makers, about the real scope of the challenge. For example, there are 665 households on waiting lists for affordable housing in Duluth, but due to lack of resources, we build about 12 units a year. Enlist the private builders who know about cost control in the construction phase. Use cost control mechanisms in the private market and in the subsidized market (use modularized/panelized systems; build with metal frame instead of wood, etc.). Plan for scale - figure out how to build 10, 50-unit buildings over 5 years and fund that rather than a building every other year.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least three people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Additional participant contributions

Workshop participants shared several additional comments throughout the process that are listed below.

- Participants would love to see continuum of care statistics for Greater Minnesota and/or the northeast region. MDH cannot disaggregate the data this way at this at this point, but they are looking at statistics on the mode of transmission in rural vs. metro areas and for different demographic groups.
- There are limited resources available in greater Minnesota (e.g., social and support services). Providers want to know what is available in their area.
- There is huge stigma around HIV in greater Minnesota. We need to have that person-to-person contact between a patient and a provider. The phone is not as personable; clients have expressed not liking the phone. We need "best practices" for clinicians/providers.
- The point of infection is more important than diagnosis—medical diagnoses seem frivolous because it seems like the last straw.
- There is a problem with the disease focus; basic needs and stability are important. However, even if people have their needs met, people avoid the doctor (e.g., transgender individuals). Transgender people don't want to have to educate their doctors. Doctors don't even know what cis-gender means. We need a billboard campaign to create awareness and start conversations.
- The tactics that are selected for the Strategy need to have multiple bangs for the buck, local government buy-in, consistency and strong messages, and balance a one-size-fits-all approach with specific needs in specific areas.
- This work requires us to broaden stakeholder perspectives (e.g., include education, criminal justice, etc.).
- We need an HIV/AIDS lobbyist. There is low morale, faith, confidence, and knowledge about the system/administration and where funding is coming from. There is low faith that anything that needs to be funded will.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS in Northwest Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in Northwest Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

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Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Minnesota HIV Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop, and offered a web survey to individuals who were unable to participate in the workshop.

To ensure geographic representation across Minnesota in this process, feedback was sought through workshops and web surveys in each of eight regions of the state. This is a summary of the facilitated workshop focused on ending HIV/AIDS in the northwest region. The workshop was conducted on May 23, 2018, in Bemidji, Minnesota. This summary also includes findings from the web survey respondents.

Participants

Workshop participants

Ten people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

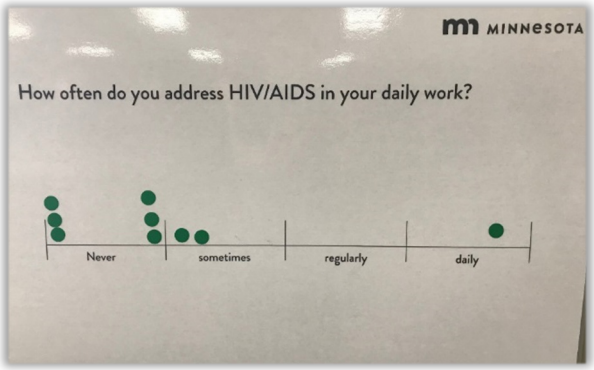
Table 1. Roles of workshop participants

	Workshop participants (N=10)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	1	10%
Chemical dependency provider	0	0%
City or county public health or human services professional	3	30%
HIV services provider	1	10%
Medical provider	0	0%
Mental health provider	0	0%
Social service provider	2	20%
Youth advocate/youth worker	0	0%
Other	2	20%
Unspecified or not pre-registered	4	40%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the MN HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" Responses ranged from never to daily, with 6 of the 9 responses being never.



Survey participants

Fifteen people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=15)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	1	7%
Chemical dependency provider	1	7%
City or county public health or human services professional	4	27%
Faith leader	0	0%
HIV services provider	1	7%
Housing provider	0	0%
Medical provider	0	0%
Mental health provider	2	13%
Social service provider	2	13%
Youth advocate/youth worker	0	0%
Other	0	0%
Prefer not to answer	0	0%
Missing	7	47%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS in the northwest region
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV in the northwest region.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the three small groups working together during this workshop, eight strategies were prioritized at least once. These are listed in Table 3. The three strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies from workshop participants

Strategies
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.
Strategy 3.5: Ensure access to services that meet the basic needs of people living with HIV (PLWH).
Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.
Strategy 5.5: Create effective information sharing partnerships and systems that produce reliable data and that inform decision-making, strategy development, and program accountability.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS in the northwest region. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 15)	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	11	73%
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.	6	40%
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	4	27%
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.	4	27%

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least four people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the three highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The six starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Develop public service announcements (PSAs): provide information, reduce stigma, inform people rates are going down, tell people they can reduce their viral loads, share where to be tested in the region, get celebrities involved, and have MDH take the lead on development of messaging. Present information on TVs in social service waiting rooms. Use social media strategies to reach youth.* ▪ Identify information and referral numbers for people to contact at the regional level.* ▪ [Conduct] information sessions with a medical doctor or people with HIV. This is not going to work for rural areas, but is still a good idea. ▪ Simplify public access to online resources including MDH website. ▪ [Offer] provider education through rural health conferences offering Continuing Education Credits (CEUs) to providers, as well as education for patients about what is included in STD testing. This could be included in provider training to clarify with patients what is included and what is not when they come in for labs.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ Educate healthcare professionals about PrEP (pre-exposure prophylaxis).* ▪ Normalize point of care HIV testing.* ▪ Provide training for service navigators at point of care. ▪ Educate professionals, especially healthcare, about PrEP and other preventative interventions. ▪ [Provide] funding for point of care testing. ▪ Identify available local resources; get an intern/student to conduct an inventory of services in the area.
Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.	▪ Create/standardize housing codes across the region (particularly in rural areas) to support safe housing for families/individuals, and support landlords to make changes (partner with Habitat construction companies, work programs, etc.). ▪ Build relationships with/educate landlords and property managers around low-income housing to create flexibility for tenants (e.g., lower requirements for credit if people can show they are working on it).* ▪ Create incentives for landlords to dedicate housing for low-income (e.g., more housing subsidies). ▪ Build/renovate/utilize tax credit housing to increase housing supply through Minnesota Urban and Rural Homesteading Program (MURL) type programs, Habitat or other rehab/building programs. Allow tax credit housing projects in greater Minnesota.* ▪ Educate renters about housing and skills for moving into better housing.

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ [Host] one-day seminars with continuing education credits. ▪ Hold groups and informational meetings in all communities. Provide county human services, public health, mental health, housing authorities, and church communities or others that will listen with information to give to their clients. ▪ Work with professionals to bring the issue forward. ▪ [Offer] e-learning for all health professionals, including mental health professionals. Highlight easy to understand statistics and education on locations to obtain help. ▪ [Run] ads on local TV regarding HIV. ▪ Make up-to-date education available on YouTube that local public health agencies could use for educating staff and the public as needed.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ Encourage and give incentives to clinics to provide services. ▪ [Offer] needle exchange programs and [provide] rural HIV treatment access with insurance coverage. ▪ [Implement an] ad campaign or news reports. [Offer] local education updates related to HIV with no charge to attend. ▪ Educate primary care providers on PrEP -- most don't know about it or use it. ▪ Utilize northwest local public health departments who offer HIV testing to begin offering PrEP. ▪ Offer opportunities for syringes to be turned in (i.e. drop off locations). Needle exchange is not universally supported by policy makers in the northwest region, currently, and this is a beginning tactic they may be amenable to.
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.	▪ Make sure our legislators are aware of health care barriers. ▪ [Use] inclusive language with minimal "red tape" for all sexual health services.
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.	▪ [Host a] one-day seminar with continuing education credits for attending.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least four people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Additional participant contributions

Workshop participants shared additional input which is described below.

- There are limited mental health providers and treatment options in the northwest region. This is an important piece of ending HIV.
- Information is very empowering to people. It is cheaper to provide information and prevention than to treat the problem once it occurs.
- There are important barriers to housing in the northwest region.
  - There are rental vouchers, but fair market rate is above the voucher so clients have to come up with the difference.
  - There is limited housing stock. Even though there are vouchers, people can't find housing; people are sometimes on the waitlist for five years.
  - Good safe housing is also needed; landlords can have terrible housing, but they don't feel they have to fix it because if someone doesn't want to rent from them, they'll find someone else.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS Among Injection Drug Users in Minnesota

SUMMARY OF COMMUNITY STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS Among Injection Drug Users in Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

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Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop.

This is a summary of the facilitated workshop focused on ending HIV/AIDS among injection drug users (IDU). A workshop focused on IDU was held because new infections among IDU – particularly IDU who are also men who have sex with men -- have increased over the last few years. While the numbers remain relatively low compared to other modes of exposure, with the growing opioid epidemic, the potential for an HIV outbreak among IDU in Minnesota is concerning. The workshop was conducted on May 29, 2018, in Minneapolis, Minnesota. This summary also includes findings from a survey that was offered to individuals who were invited to participate in the workshop, but unable to attend.

Participants

Workshop participants

Fifteen people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

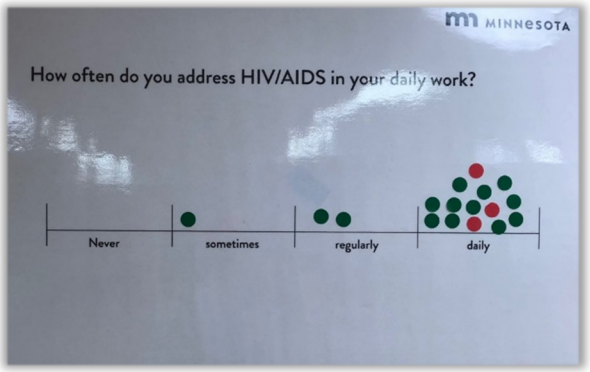
Table 1. Roles of workshop participants

	Workshop participants (N=15)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	8	53%
Chemical dependency provider	3	20%
City or county public health or human services professional	1	7%
HIV services provider	11	73%
Medical provider	1	7%
Mental health provider	2	13%
Social service provider	5	33%
Youth advocate/youth worker	2	13%
Other	4	27%
Unspecified or not pre-registered	0	0%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" Responses ranged from sometimes to daily, with a majority of the responses being daily.



Survey participants

Eight people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=8)
Role or area of work	N
Advocate for, or member of, high-risk population[a]	1
Chemical dependency provider	1
City or county public health or human services professional	3
Faith leader	0
HIV services provider	0
Housing provider	0
Medical provider	1
Mental health provider	0
Social service provider	0
Youth advocate/youth worker	0
Other	2
Prefer not to answer	0
Missing	2

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS among injection drug users in Minnesota
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV among injection drug users.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the four small groups working together during this workshop, 11 strategies were prioritized at least once. These are listed in Table 3. The four strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies

Strategies
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.
Strategy 2.2: Engage community leaders, non-profit agencies, people living with HIV (PLWH), and other community members to identify and to address barriers that prevent testing and person-centered care.
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.
Strategy 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.
Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.

Note. The strategy numbers (e.g., 1.4) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS among injection drug users. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 8)
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	6
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	3
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	3
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	3

Note. The strategy numbers (e.g., 1.4) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least three people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the four highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The eight starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ Expand AIDS Line services to provide safe consumption services preferably by phone. Could be a call in connection to a peer, [there are] safety issues [with this]. ▪ Integrate syringe services programs (SSP) into other services (e.g., primary care, treatment agencies, and emergency rooms). Imbed this in places like Positive Care. This will improve retention in care and this would also help [address] transgender needs. [Increase number of] safe disposal sites; [implement] syringe take back at pharmacies, community incinerator, and community visible disposable sites (like in Denver). Need more licensed alcohol and drug counselors and Rule 25 assessors integrated at SSPs.* ▪ [Implement] peer delivery of syringes. More money is needed for supplies. [Implement] secondary exchangers (replicate Washington Heights model) and drug user organizing. Engage drug consumers in design and delivery.* ▪ [Make] Syringe Access Initiative (SAI) required. It should be changed to say that a pharmacy/pharmacist MUST (not may) sell up to 10 syringes without a prescription. This should be legally challenged. ▪ [Educate] medical providers and agencies about what is harm reduction and why/how it works. Reframe recovery to "any positive step" and away from just treatment and/or abstinence.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ [Decrease] structural discrimination. Decriminalize possession of syringes and narcotics through legislation.* ▪ [Address] systemic racism. Go where people are to exchange needles—do not just do the service at white agencies or by white people. Go to agencies of color [to implement] needle exchange. Bring people to the table to make better decisions.* ▪ Increase access to health care for people of color. Provide translation; [improve] health literacy for people from different countries. Incorporate non-western medical models into western models.

Table 5. Brainstormed tactics from workshop participants (continued)

Prioritized strategies	Potential tactics
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ Offer ongoing mental health/substance use care and supports to people living with HIV (PLWH) regardless of exposure category. Provide comprehensive assessment and immediate referrals for integrated care.* ▪ Increase peer supports and case management for PLWH with mental health and substance use issues.* ▪ Eliminate insurance barriers (especially to treatment); explore the Certified Community Based Health Clinics (CCBHC) concept. ▪ [Make] clinicians available to do assessment and follow up services rather than relying on referrals.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	▪ [Implement] looser eligibility requirements (Housing first, harm reduction housing). Increase flexibility in funding. Have tighter network of housing resources and increase [their] congruence.* ▪ [Eliminate] sobriety requirements attached to housing. ▪ [Provide] support services attached to housing support to increase retention. [Start] "de-siloing services" and making them more accessible.* ▪ Implement "sticky services" [as done by the] Hearth Connection, [where] services are attached to individual not the type of housing they have. ▪ Increase flexibility [of funding]. Prioritize state funding to pay for support services.

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Offer more conferences and webinars to professionals. [Use] more PSAs to reach high-risk populations.
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	▪ [Implement] same-day initiation of antiretroviral therapy (ART) upon diagnosis. This may require adding access to ART in testing locations so people do not fall between the cracks when referred elsewhere. ▪ Develop an easy to use referral system to link individuals to a provider who specializes in HIV treatment.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ Educate about options in at-risk populations. Often persons who may have risks for certain diseases don't understand options in prevention of that disease. ▪ Offer more education to providers regarding PrEP and PEP. Expand syringe services programs to rural areas. ▪ Work with pharmacies to reduce the stigma around purchasing syringes. At most pharmacies it's up to the pharmacist if they want to sell them or not.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ Integrate on-demand treatment into HIV care.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least three people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Additional participant contributions

Workshop participants offered additional input throughout the facilitated activities. These insights are listed below.

- Participants indicated that the fundamental question that we should ask is, "Why are people falling out of care (i.e., not retained)? What are the demographics of these people?"
- Participants provided feedback about many aspects of the Minnesota HIV Strategy.
  - They recommended that the Strategy be more focused on person-centered and culturally appropriate care and that it be driven by impacted populations.
  - Four elements of the Strategy that were specifically identified as important were: early intervention, referral and follow-up (warm handoff), access to care, and linkage to care.
  - The Strategy should articulate the overlap with substance abuse disorder and the overdose crisis.
  - The Strategy should focus on harm reduction and treatment access. Some specific ways this could be integrated include:
    - Strategy 2.3 should include key populations like injection drug users (especially those of color).
    - Strategy 3.4 should specify "evidence-based" substance use services, and the strategy should reference retaining in care in addition to just access.
    - Strategy 4.4 should include harm-reduction resources such as wet housing.
- There are important barriers to accessing HIV care and information, including individual barriers and policy barriers.
  - There is an inequity in access to HIV information. While white men who have sex with men have access to HIV information, members of the black and Latino communities do not.
  - IDU stigma is very high, and because of this, some choose not to access services due to shame.
  - Professionalization and lack of support are also barriers; some PLWH need more hands on or supportive care, especially when they have co-occurring issues like mental health or substance use.
  - There are insurance barriers for IDU to access PrEP and PEP; especially for those who have Medicare.
  - The Syringe Access Law is inefficient and creates shame. It actually legitimizes use, is stigmatizing, and should be abolished.
    - Participants recommend renaming syringe services to include harm reduction, possibly by renaming to Drug User Care Services and including overdose prevention measures.
    - Expand strategy to cover all IDU/drug users to create human-centered approach.
- There is a need for Harm Reduction Housing, which provides harm reduction supports and supervised injection.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS in South Central Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in South Central Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

Contents

Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Minnesota HIV Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop, and offered a web survey to individuals who were unable to participate in the workshop.

To ensure geographic representation across Minnesota in this process, feedback was sought through workshops and web surveys in each of eight regions of the state. This is a summary of the facilitated workshop focused on ending HIV/AIDS in the south central region. The workshop was conducted on May 31, 2018, in Mankato, Minnesota. This summary also includes findings from the web survey respondents.

Participants

Workshop participants

Twenty people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

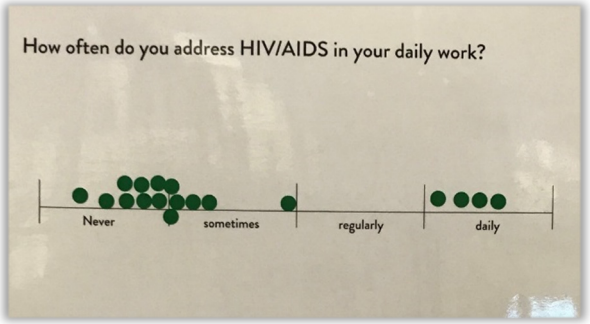
Table 1. Roles of workshop participants

	Workshop participants (N=20)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	1	5%
Chemical dependency provider	1	5%
City or county public health or human services professional	10	50%
HIV services provider	3	15%
Medical provider	0	0%
Mental health provider	2	10%
Social service provider	2	10%
Youth advocate/youth worker	0	0%
Other	2	10%
Unspecified or not pre-registered	2	10%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the MN HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" The 18 responses ranged from never to daily, with the largest share of responses being never.



Survey participants

Ten people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=10)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	0	0%
Chemical dependency provider	0	0%
City or county public health or human services professional	5	50%
Faith leader	0	0%
HIV services provider	0	0%
Housing provider	0	0%
Medical provider	0	0%
Mental health provider	0	0%
Social service provider	0	0%
Youth advocate/youth worker	0	0%
Other	2	20%
Prefer not to answer	0	0%
Missing	3	30%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS in the south central region
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participant's insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV in the south central region.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the five small groups working together during this workshop, 13 strategies were prioritized at least once. These are listed in Table 3. The five strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies from workshop participants

Strategies
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.1: Employ high-impact public health approaches to identify and to re-engage individuals who are out of HIV care and treatment.
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.
Strategy 3.5: Ensure access to services that meet the basic needs of people living with HIV (PLWH).
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.
Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS in the south central region. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 10)	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	6	60%
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.	4	40%
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	3	30%
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	3	30%
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.	3	30%
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	3	30%

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least three people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the five highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The ten starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ [Host a] regional conference with breakout sessions for differing levels of knowledge. [Invite a] comprehensive group – school staff, police officers, etc. This could be a webinar.* ▪ [Create a] regional hotline to link people living with HIV (PLWH) to resources. ▪ Provide an HIV-specific education session or outreach to local schools serving students age 13 and older through local public health. This could be paired with existing presentations that focus broadly on sexual health.* ▪ Conduct education or outreach at chemical dependency treatment facilities. This could be done by the regional drug task force. ▪ Host a “day in the life" session where PLWH share stories and describe day-to-day life to students. ▪ [Have the] state HIV specialist conduct visits to rural/greater Minnesota’s small communities to do monthly outreach and testing at clinics where people with high-risk visit. ▪ Identify and engage with cultural community leaders to ensure they have accurate information about HIV and can serve as a liaison between providers and cultural communities.
Strategy 3.1: Employ high-impact public health approaches to identify and to re-engage individuals who are out of HIV care and treatment.	▪ Develop a referral process to local public health by the Minnesota Department of Health (MDH).* ▪ [Increase] public health’s involvement with individuals doing Directly Observed Therapy (DOT) until [they reach an] undetectable viral load. ▪ Educate providers about processes for referral, access to medication, and funding. ▪ Provide person-centered, holistic education to patients with HIV via public health. Education does not always translate to behavior change but unless you educate you won't be able to impact behavior. ▪ [Provide] holistic nurse case management with medication administration, education, referral to services, and care coordination.* ▪ [Provide] provider education around routine testing (i.e., pregnancy with syphilis, tuberculosis). ▪ Offer testing in office and at community events by public health.

Table 5. Brainstormed tactics from workshop participants (continued)

Prioritized strategies	Potential tactics
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ [Implement an] outcome-based payment [system]. ▪ [Increase] cultural competence. Work with community organizations and populations from high-risk populations. ▪ [Address] understanding discrepancy. [Provide] focused education for true need and misunderstanding. ▪ Reduce stigma through a provider outreach initiative. Link providers to groups who are not accessing care.* ▪ [Improve] access to care. ▪ [Increase] availability to bed space/programs. [Implement] dual programs [for mental health and substance abuse]. ▪ Increase awareness among providers. Educate [to improve] provider competency. [Teach providers to use a] standardized screening process [for mental health and substance abuse issues].* ▪ [Change] government rules and regulations. Licensing rules need to be integrated. Regulations need to be loosened up. ▪ [Provide] treatment in the emergency department specifically for mental health and substance use disorders.
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	▪ [Provide] ongoing professional education through webinars and conferences.* ▪ Build on existing coalitions and networks.* ▪ Integrate HIV and sexually transmitted disease (STD) education in schools and communities. ▪ Refine referral networks.
Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.	▪ Develop an inventory of best practices in other states. MDH/DHS take the lead to collect and or compile these resources/best practices.* ▪ Offer training for professionals. MDH/DHS conduct regional training on the best practices, specifically for interventions that have worked in similar geographic regions (rural) and for particular communities. ▪ Identify successful programs to model hands-on experience. [Look to] programs that have worked (e.g., King County, Seattle). ▪ Build a large collaboration within the region to maximize limited resources. (e.g., social networking, sharing what works, building relationships with gatekeepers in community/governments). ▪ [Provide] capacity funds for public [messaging] of prevention, care, and treatment services. [Conduct] outreach to other service providers.*

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Develop online education programs and webinars. ▪ Provide communication content and tools to local public health and community partners to deliver in their settings and in any outreach work they do. ▪ [Conduct] outreach activities within schools, community events, and clinics to ensure all are aware of prevention and appropriate testing.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ [Increase] education. [Ensure] private access.
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.	▪ Lobby for legislative action and [provide] education for elected officials. ▪ [Implement] legislation to secure that pre-existing conditions are always covered.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ Attempt to normalize the conversations.
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.	▪ Provide resources and support around individually personalized strategies to providers and their support staff that accept the care of HIV positive clients.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ MDH and insurance carriers need to provide coverage for [mental health and substance abuse] services. Offer incentives to caregivers if they provide services. ▪ Recruit additional mental health providers for rural Minnesota even if through tele-medicine. ▪ [Implement] legislation and [provide] funding to support this important area.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least three people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Additional participant contributions

Workshop participants offered additional input which is summarized below.

- Participants made connections between the work with HIV and that with tuberculosis (TB). They suggested that testing for and management of HIV should be done like TB. They indicated that they know the numbers of TB cases, but don't have the same records for people living with HIV. Because it's a reportable infectious disease like TB, they recommended that it be treated like that, but the care coordinator position to do so is missing.
- Participants inquired as to whether MDH informs regional public health about new HIV cases in the region, and if not, suggested that this happen.
- Participants recommended collaborating with established systems to this work (e.g., have probation officers conduct HIV tests while doing drug testing).

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS in Southeast Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in Southeast Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

Contents

Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Minnesota HIV Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop, and offered a web survey to individuals who were unable to participate in the workshop.

To ensure geographic representation across Minnesota in this process, feedback was sought through workshops and web surveys in each of eight regions of the state. This is a summary of the facilitated workshop focused on ending HIV/AIDS in the southeast region. The workshop was conducted on May 14, 2018, in Rochester, Minnesota. This summary also includes findings from the web survey respondents.

Participants

Workshop participants

Eight people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

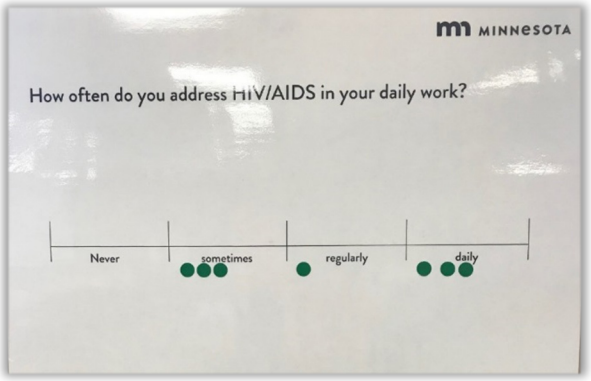
Table 1. Roles of workshop participants

	Workshop participants (N=8)
Role or area of work	**N**
Advocate for, or member of, high-risk population[a]	0
Chemical dependency provider	0
City or county public health or human services professional	3
HIV services provider	0
Medical provider	2
Mental health provider	0
Social service provider	0
Youth advocate/youth worker	0
Other	2
Unspecified or not pre-registered	1

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the MN HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" The seven responses ranged from sometimes to daily.



Survey participants

Six people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=6)
Role or area of work	**N**
Advocate for, or member of, high-risk population[a]	1
Chemical dependency provider	0
City or county public health or human services professional	1
Faith leader	0
HIV services provider	1
Housing provider	1
Medical provider	1
Mental health provider	1
Social service provider	0
Youth advocate/youth worker	1
Other	1
Prefer not to answer	0
Missing	2

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS in the southeast region
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV in the southeast region.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the two small groups working together during this workshop, six strategies were prioritized at least once. These are listed in Table 3. The two strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies from workshop participants

Strategies
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.
Strategy 2.2: Engage community leaders, non-profit agencies, people living with HIV (PLWH), and other community members to identify and to address barriers that prevent testing and person-centered care.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS in the southeast region. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 6)
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	4
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	3
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.	2
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	2

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least two people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the two highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The four starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Include HIV/STD testing quality measure for reimbursement purposes. ▪ [Provide] system-wide/user-friendly provider trainings. ▪ Increase community education. Start with community education then progress to comprehensive sex education.* ▪ [Provide] comprehensive sex education in Minnesota which includes HIV and STD education. ▪ Develop STD/HIV fact sheets for teachers. ▪ Connect education/awareness to an HIV/STD event. ▪ Develop social media messaging. [Use] technology, apps, Facebook, and Instagram.*
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	▪ Conduct a gaps analysis for what exists for curriculum and resources so that we can identify all organizations working on HIV. Build a list of organizations and an updated resource guide.* ▪ [Conduct a] community needs assessment to identify community needs around HIV/AIDS. ▪ Create a policy to integrate a standard around HIV into the school system. ▪ [Develop] policy guidelines for healthcare standard practices. ▪ Change the county policy that they can't do STD/HIV testing on anyone under 18. ▪ Build partnerships across sectors (local health, colleges, mobile testing, housing providers, corrections, treatment, medical providers) –efforts are being duplicated. Get people at the same table via convening, conference, and/or co-location.* ▪ Create a social campaign for specific local numbers/data to bring awareness to people that it is a local issue (both community and providers).

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ [Provide] education to help ensure HIV risk awareness for all, but targeted to those most at risk. ▪ Identify and provide educational tools and training for those who provide services to youth and high-risk individuals such as schools, mental health services, sexual health services, STD clinics, jails, clinics and hospitals, and health and human services agencies.
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.	▪ [Hold] targeted community conversations that include contacts not immediately identified as partners (i.e., outside of other local planning) or [have] strategic involvement with regular local community health needs assessments. [Engage] with public health and local hospitals to identify HIV/AIDS strategies that connect with other general priorities set by the community.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ Identify where patients can find free or low-cost (and ideally Spanish speaking) mental health and substance use services and care. ▪ Work through legislation to enact bills to ensure access.
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	▪ Have advocates and agencies serving PLWH participate in the Continuum of Care to ensure that the homeless response system is integrating the prevention, care, and treatment that it can/should. ▪ Start from the top down.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least two people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS in Southwest Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in Southwest Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Contents

Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Minnesota HIV Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop, and offered a web survey to individuals who were unable to participate in the workshop.

To ensure geographic representation across Minnesota in this process, feedback was sought through workshops and web surveys in each of eight regions of the state. This is a summary of the facilitated workshop focused on ending HIV/AIDS in the southwest region. The workshop was conducted on June 6, 2018, in Worthington, Minnesota. This summary also includes findings from the web survey respondents.

Participants

Workshop participants

Eleven people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

Table 1. Roles of workshop participants

	Workshop participants (N=11)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	2	18%
Chemical dependency provider	0	0%
City or county public health or human services professional	4	36%
HIV services provider	0	0%
Medical provider	3	27%
Mental health provider	0	0%
Social service provider	1	9%
Youth advocate/youth worker	1	9%
Other	3	27%
Unspecified or not pre-registered	1	9%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" Responses ranged from never to daily, with 8 of the 11 responses being sometimes.

Survey participants

Fourteen people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=14)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	1	7%
Chemical dependency provider	0	0%
City or county public health or human services professional	4	29%
Faith leader	0	0%
HIV services provider	0	0%
Housing provider	0	0%
Medical provider	1	7%
Mental health provider	0	0%
Social service provider	0	0%
Youth advocate/youth worker	0	0%
Other	4	29%
Prefer not to answer	0	0%
Missing	5	36%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS in the southwest region
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV in the southwest region.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the three small groups working together during this workshop, seven strategies were prioritized at least once. These are listed in Table 3. The three strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies from workshop participants

Strategies
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.
Strategy 2.2: Engage community leaders, non-profit agencies, people living with HIV (PLWH), and other community members to identify and to address barriers that prevent testing and person-centered care.
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS in the southwest region. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 14)	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	8	57%
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	6	43%
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	4	29%

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least four people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the three highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The six starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ [Provide] formal training for health providers (all fields) and local public health staff. A lot is old. Pre-exposure prophylaxis (PrEP) education. Ob/Gyns are uninformed. Update continuing medical education. ▪ [Inform] community members; more PSAs about good tests [and] good drugs. Do a campaign to educate; dovetail with screening. ▪ [Teach] sexual health in settings including at schools. Education in schools [varies].* ▪ Provide education. Clinics should explain screening criteria: how often, who is tested, age limits. ▪ [Provide] more education to culturally specific communities. Think about cultural needs and consult the community or a community leader when developing educational activities.*
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.	▪ Conduct focus groups or public forums. Identify trusted leaders in the community, churches, and tribes to take the lead. Identify local care providers willing to participate.* ▪ Involve case managers to connect with people living with HIV. Involve key stakeholders. Start with a generalized approach to identify champions. Create safe-places discourse appointments. ▪ Identify trusted leaders as champions for integrated care that minimizes stereotyping. Include youth as leaders.* ▪ [Improve] messaging. Use social media/PSAs. [Ensure] accurate information is disseminated. Share basic HIV-101 education. Use appropriate social media platforms.

Table 5. Brainstormed tactics from workshop participants (continued)

Prioritized strategies	Potential tactics
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	▪ Ask JBS (a large, local employer) to add screening. ▪ Develop a relationship with schools; find out their sex education curriculum. Start a conversation about how HIV prevention could be implemented in schools. [Offer] basic education about HIV (e.g., transmission, etc.). ▪ [Provide] state support to try to get schools talking about HIV and standardized sex education.* ▪ Develop relationships across sectors and have conversations. Frame it in a way so that it matters to others like JBS.* ▪ Host a meeting with people from different sectors to talk about resource lists and ensuring that people within each organization know how to navigate them. ▪ Get undocumented people connected to telemedicine at Hennepin County Medical Center (HCMC) via the HCMC Positive Care Clinic. ▪ [Conduct an] advertising campaign to increase awareness of HIV/AIDS across all sectors.

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ [Implement] media campaigns, continuing education for professionals, education by community leaders and trusted messengers so they can get the message out. ▪ Provide regional updates and training to health professionals. ▪ Offer HIV education in public and private schools. Also provide education in community organizations such as the YMCA. ▪ [Confirm that physicians] in greater Minnesota are up to date as far as current HIV care (medications and follow up). [This may] perhaps make doctors think about HIV. [Greater Minnesota HIV] rates are often a lot lower than metro [rates], [it is] hard to sustain programs in these areas. ▪ [Implement] testing for new immigrants coming from other countries [to understand] how many are coming here with the disease. ▪ Use social media to get an updated message out. ▪ Implement local classes or programs that are part of an already existing system or require health professionals and students to attend classes.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	▪ [Identify] a community outreach worker who is trained and can bring the message to their own community and be the liaison with the medical community. ▪ [Improve] education, translation, and patient advocacy. [Implement] audio/visual services since many patients cannot read or write in their own language. ▪ [Hire] well-trained staff able to offer empathy and support in a caring non-judgmental way.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ [Address the] long wait to be seen by a therapist and lack of affordable mental health services. ▪ [Implement] more incentives for mental health providers and substance abuse help. There is often a lack of resources in greater Minnesota--namely the number of providers able to help due to burnout and low numbers of this profession graduating with degrees in this field. ▪ Provide statewide percentage reimbursement of student loans for those who are trained as counselors and will serve within this capacity for a set amount of time. ▪ Develop mental health and substance abuse programs and facilities for southwest Minnesota.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least four people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Additional participant contributions

Participants shared additional input related to the cultural diversity of residents in the region, the need to involve the private sector in the work to end HIV, geographic challenges in the region, housing, and general concerns about infrastructure.

- Participants discussed how there are many diverse, non-English speakers in the region. Approximately 54 languages or dialects are spoken in the region. There is a need for both on-site and language line services; people like different choices. Additionally, stigma is a major issue in cultural communities that creates a barrier to care. People don't want others in their community to discover they're HIV positive; they worry that if the translator knows their status the rest of the community might find out.
- Participants expressed a need to improve access to basic health care and preventative care among the diverse community members. They acknowledge that the best approach for connecting to these communities and sharing information is through churches/faith based communities.
- Participants stressed that employers and the private sector need to be involved. In Worthington, JBS is a major employer. Some of JBS's policies are not well understood by employees and result in barriers to care. For example, many people believe that JBS will deduct "points" from employees for missing work, even for doctor's appointments. So people don't go to the doctor because if they lose enough points, they will lose their jobs. Additionally, participants recommended reaching out to JBS to help them understand why the issue is important and to request that they help share information about HIV and/or help conduct HIV screenings.
- Participants shared some of the particular challenges related to the geographic location of their counties. Because they are near the state border, HIV-positive individuals frequently move to bordering states, then back. People are lost from the system of care with these moves.
- Participants indicated that there is a big housing problem in area. The new tenants union may help. There is a need for City involvement to enforce laws and rules for landlords.
- Participants had an overall concern about infrastructure in the region and potential implications for the feasibility of their suggested tactics. They noted that there is a higher incidence of HIV than tuberculosis in Nobles County, but there is much more education about tuberculosis.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

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At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS Among Transgender People in Minnesota

SUMMARY OF COMMUNITY STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS Among Transgender People in Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
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Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

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Introduction

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Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop.

This is a summary of the facilitated workshop focused on ending HIV/AIDS among transgender people. A workshop specifically focused on transgender people was held because, according to current national estimates, approximately a quarter (22-28 percent) of transgender women are living with HIV and an estimated 56 percent of African American transgender women are living with HIV.[1] The workshop was conducted on May 16, 2018, in Minneapolis, Minnesota. A survey was also offered to individuals who were invited to participate in the workshop, but unable to attend. Only two individuals participated in the survey focused on ending HIV among transgender people. Due to the low response, survey data are not included in this summary.

[1] Clark, H., Babu, A.S., Wiewel, E.W., Opoku, J., & Crepaz, N. (2017). Diagnosed HIV infection in transgender adults and adolescents: Results from the National HIV Surveillance System, 2009-2014. *AIDS and Behavior, 21*(9): 2774-2783. doi: Abstract publication among Transgender people (https://www.ncbi.nlm.nih.gov/pubmed/28035497)

Workshop participants

Fifteen people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

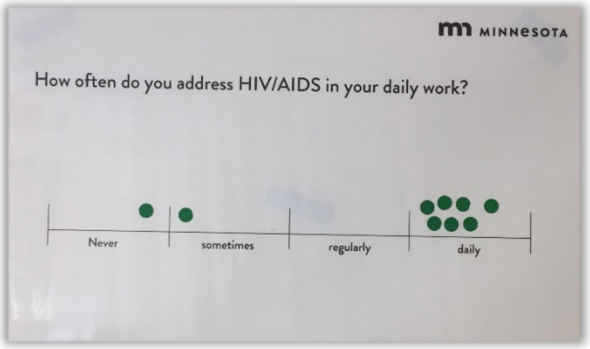
Table 1. Roles of workshop participants

	Workshop participants (N=15)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	8	53%
Chemical dependency provider	1	7%
City or county public health or human services professional	2	13%
HIV services provider	8	53%
Medical provider	1	7%
Mental health provider	1	7%
Social service provider	0	0%
Youth advocate/youth worker	1	7%
Other	1	7%
Unspecified or not pre-registered	1	7%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: “How often do you address HIV/AIDS in your daily work?” Responses ranged from never to daily, with 7 of the 9 responses being daily.



Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS among transgender people in Minnesota
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants’ insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Prioritized strategies

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV among transgender people.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the three small groups working together during this workshop, 13 strategies were prioritized at least once. These are listed in Table 2. During voting, however, the participants chose to vote for one of the overarching goals rather than the strategies. As such, the two strategies and one goal that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 2. Prioritized strategies

Strategies	
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	
Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.	
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.	
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.	
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	
Strategy 3.5: Ensure access to services that meet the basic needs of people living with HIV (PLWH).	
Strategy 4.1: Identify gaps in affordable housing statewide.	
Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.	
Strategy 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.	
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	
Strategy 5.1: Create a leadership structure that is held accountable for implementing and updating this strategy. This leadership structure will include key stakeholders that this strategy affects, such as government leadership, community-based organizations, PLWH, and Minnesota residents that the HIV epidemic hits hardest.	**Goal 5: Achieve a more coordinated statewide response to HIV**
Strategy 5.5: Create effective information sharing partnerships and systems that produce reliable data and that inform decision-making, strategy development, and program accountability.	

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Tactics

First, participants worked in small groups to brainstorm possible tactics for the one goal and two strategies that received the greatest number of votes. Table 3 lists the tactics that were brainstormed for each. The six starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 3. Brainstormed tactics

Prioritized strategies	Potential tactics
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ Hire from the transgender community.* ▪ Develop medical strategies that are conducive to the patient's life and needs as a transgendered individual.*
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	▪ Continue to build and keep money going into the right areas/organizations/agencies that are already supplying supportive housing so that they can expand housing opportunities. Have resources for housing (transportation, food, supplies, etc.).* ▪ Continue to build affordable houses (i.e., [requiring] 30% of income or less). Help maintain naturally occurring affordable housing at a reasonable cost (NOAH impact fund). Increase grants for housing providers to purchase property to keep it affordable. ▪ Allow for financing at a legislative level to provide housing/resources for long-term homelessness. [Use] Minnesota Housing Tax Credit financing. Expand the target population for supportive housing from just high priority homeless population to a broader array.* ▪ Take advantage of waiver for Medicare to fund supportive services (housing related services).
Goal 5: Achieve a More Coordinated Statewide Response to HIV.	▪ Provide funding that is "open-source" (organizations define own goals, restrictions not imposed by grants). DHS, MDH, CDC pool funding and streamline process for grantees. Unify grant application process [to have] "coordinated entry" for grants.* ▪ Provide capacity-building, operating funds for small grassroots community-connected organizations to better compete for grants.* ▪ Push for transparency from MDH/DHS on projects and service delivery and resources. ▪ Eliminate zip code restrictions on people of color/marginalized populations for funding.

Additional participant contributions

Participants offered some additional feedback during the workshop. First, they noted that transgender representation is needed on the Minnesota Council for HIV/AIDS Care and Prevention. Additionally, they shared that building trust is a critical need. Transgender people face barriers to accessing care because of the stigma they face and because of previous trauma they have experienced. More transgender people should be employed in the field (rather than just served) to help improve this trust and reduce barriers to care.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

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At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.

Ending HIV/AIDS in West Central Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in West Central Minnesota

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

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Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy (the Strategy). The Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop, and offered a web survey to individuals who were unable to participate in the workshop.

To ensure geographic representation across Minnesota in this process, feedback was sought through workshops and web surveys in each of eight regions of the state. A facilitated workshop focused on ending HIV/AIDS in the West Central region was planned for April 16, 2018, in Moorhead, Minnesota but was canceled due to low participant registration. This is a summary of the findings from the web survey respondents.

Survey process and participants

Process

The survey asked respondents to identify the three strategies that they feel are most important for their region, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it.

Participants

Eighteen people provided input via the survey. Table 1 shows survey participants' roles or areas of work. Participants could select multiple roles or areas of work.

Table 1. Roles of survey participants

	Survey participants (N=18)	
Role or area of work	**N**	**%**
Advocate for, or member of, high risk population[a]	1	6%
Chemical dependency provider	0	0%
City or county public health or human services professional	4	22%
Faith leader	0	0%
HIV services provider	1	6%
Housing provider	0	0%
Medical provider	3	17%
Mental health provider	0	0%
Social service provider	0	0%
Youth advocate/youth worker	0	0%
Other	4	22%
Prefer not to answer	1	6%
Missing	7	39%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Prioritized strategies

Web survey respondents were asked to identify strategies that they thought were most important for ending HIV/AIDS in the west central region. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 2.

Table 2. Prioritized strategies from survey participants

Strategy	N (out of 18)	%
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.	10	56%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	8	44%
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	6	33%

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least six people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 3 lists the tactics that they recommended.

Table 3. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Start with giving better information to school-aged children. Not just how to wear a condom, but more [information on] what HIV is, how it is transmitted, prevention, [and] not to be afraid of normal contact. ▪ [Have] public forums, focus groups, [and] events. ▪ [Make] information available like brochures [that can be accessed] on a smart phone [because] the younger generation is very tech savvy. ▪ Include information at all educational levels from elementary to the college. Have professionals or educators in the field trained to relay the information, and possibly certify people to be the educators or professionals.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ [Implement] programs for those that are under-insured or that have no insurance so [that] those individuals can be [informed] of available resources and because the medication is so expensive. Indian Health Services is not able to provide needle-exchange services; [they] often have to refer to tribal health [centers], which are only open limited times during the week. This is great for those that live on the reservation, but many of the patients live outside of the reservation. ▪ Do more education in greater Minnesota around the advantages of PrEP, PEP, and syringe exchange programs to increase buy-in. Communities in this area are extremely resistant to "harm reductionist" strategies due to their perceived "counter-intuitive nature." If there is buy-in for programs such as these, then funds and resources can and will follow. There are energized people in the community and local organizations to implement this work, but they cannot do it without proper supports. ▪ All payers should pay 100% of treatment costs for both patient and partner. ▪ Utilize mobile or home-based efforts to better reach rural areas. ▪ Meet people where they are with real-time services and support. Don't wait for them to come to [a] facility. Provide a holistic approach to assess all health risks and provide hands-on case management. ▪ Break down the stigma of obtaining these services. This is a rural, conservative area and the most significant barrier to people obtaining any of these services is cultural. Enlisting churches to help would be a major breakthrough.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least six people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Table 3. Recommended tactics from survey participants (continued)

Prioritized strategies	Recommended tactics
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ Bring a variety of people to the table and educate them - this is the most important piece in addressing issues about HIV stigma, racism and structural discrimination on a systems level. People do not want to discuss the role racism, stigma, and other discrimination/oppression plays in not only "othering" certain communities, but also perpetuating these public health crises. This is mostly because the general community, of both professionals and the public, do not believe that these issues exist in their community unless they are directly impacted by it. This is very dangerous. ▪ Provide information to broader audiences to encourage diversity. ▪ Have pastors and local politicians openly use the term "HIV" to break down the stigma.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least six people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

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Talking Circles Regarding HIV/AIDS in Native American Communities

A SUMMARY OF KEY THEMES

July 2018
Prepared by Wilder Research

MINNESOTA

Talking Circles Regarding HIV/AIDS in Native American Communities

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

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Introduction

In 2018, the Minnesota Departments of Health (MDH) and Human Services (DHS) released the Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

To assist with development of the Minnesota HIV Strategy, MDH conducted a number of focus groups to identify critical needs in each region of the state as well as within cultural communities that are at higher-risk for HIV. Unfortunately, MDH was not able to capture as much input from Native American community members or providers who serve Native Americans as was desired. In order to capture additional input from these individuals, Wilder Research and MDH co-facilitated a series of talking circles as part of a session at the White Earth Harm Reduction Summit on May 2, 2018, in Bemidji, Minnesota.

A total of 24 people participated in the talking circles and were broken out into smaller groups. Participants included individuals who identify as Native Americans, medical providers, and advocates for or members of high-risk populations. Participants also included at least one person identifying as each of the following: faith or spiritual leader, chemical dependency provider, youth worker, and city or county human services or public health official. Additionally, one elected tribal official participated. The talking circles included questions about participants' thoughts or concerns about HIV in their communities, needs and barriers related to ending HIV in their communities, efforts that are underway in their communities, and suggestions for how a state agency, such as MDH or DHS, could support any existing efforts or future efforts to end HIV in their communities. The following themes were identified through the notes taken during these four talking circles. An open coding process was used to identify these themes; however, due a small number of participants, findings include some comments made by one or two people.

The summary of themes is meant to increase our understanding of HIV/AIDS in Native American communities in Minnesota and to help guide future efforts of MDH and DHS as they develop tactics to end HIV/AIDS in all communities in Minnesota and to collaborate with Native American communities to do so.

Thoughts or concerns about HIV/AIDS in Native American communities

Major themes that arose regarding issues and concerns about HIV/AIDS in Native communities included stigma associated with having a positive HIV/AIDS status and lack of services and resources for those who are infected or are at risk of infection.

Stigma*.* Participants in the talking circles described many different types of stigma associated with an HIV/AIDS diagnosis. Stereotypes and stigma are common, particularly related to: injection drug use, opioid addiction; lesbian, gay, bisexual, transgender, and queer (LGBTQ) identities; and cultural beliefs (e.g., anti-Planned Parenthood sentiment in Fargo). The lack of anonymity in a small, closely-knit community, such as White Earth, makes it difficult for people to be tested or seek services for fear of stigmatization and isolation from their community. In addition to stigma, there is a misperception that HIV/AIDS is a "white man's disease" and is not seen as a disease that impacts Native populations. Lastly, the cultural taboo around discussing sex and sexuality make it difficult to address HIV/AIDS as an issue in Native communities.

Lack of services and resources*.* The lack of services and resources was described as a general lack of providers that provide HIV/AIDS services and treatment. Providers that are located in Native American communities often lack knowledge and information about pre-exposure prophylaxis (PrEP), and other treatments. There are limited HIV services, treatment options, and resources in general (e.g., access to PrEP, Narcan, 24-hour access to syringes) and, in particular, there is a lack of appropriate health care for transgender individuals or trans-friendly health care.

Additional concerns. Participants were also concerned about poor adherence to medication regimens and concerns that data collected on Native Americans is inaccurate or incomplete and does not reflect the reality of HIV/AIDS in Native American communities. Additionally, concern was expressed about how HIV/AIDS disproportionately affects transgender women of color and how there is no strategic outreach to inform this population about medications like PrEP. There was specific concern that transgender women are not being given the proper to care to prevent infection with HIV and to properly test for it. It was pointed out that there is nothing specific in the Minnesota HIV Strategy that addresses the issues specific to this disproportionately affected population.

Greatest needs related to addressing HIV/AIDS in Native American communities

Participants identified several needs in Native American communities related to HIV/AIDS. Major themes include: 1) education, 2) adequate health care services, 3) competent providers, 4) basic needs such as housing and transportation, and 5) outreach to increase HIV awareness and promote service utilization.

Education. Participants felt that there is a need in Native American communities for early sex education and general health education. Some specific strategies or platforms for sharing information that were suggested include risk reduction programs, counseling services, community forums, educational materials, including basic life skills or strategies throughout education, having drug use educators in schools, and providing effective trainings to address issues related to HIV/AIDS.

Adequate health care services. Health care services need to be offered in a comfortable setting for people living with HIV/AIDS and those at risk for HIV. One participant described this as settings "where providers and patients are equal." Convenient clinic hours are important to reduce barriers to accessing services (e.g., open on nights and weekends) and clinics should offer more information on services that are provided. In addition to decreasing these types of barriers, participants talked about the need for culturally appropriate services and for a structural change in the health care system to allow for more time between health care professionals and patients during a medical visit. Lastly, STD testing needs to be normalized and co-occurring issues, such as mental illness, substance abuse, and homelessness, need to be addressed in tandem with HIV prevention, diagnosis, and treatment.

Competent providers. There is a need for providers who are comfortable discussing HIV/AIDS and sexual health. Additionally, there needs to be trust-building between providers and people living with HIV/AIDS. People living with HIV/AIDS should not be afraid to visit a health care provider for fear of blame or criticism (e.g., for failing to adhere to medication). One group talked about how there needs to be better treatment of patients in general. A participant said, "Give help to those who need it. Treat people as people and not in relation to the availability of resources."

Basic needs. There is a need for housing, mentioned specifically was nurse-staffed apartments for people living with HIV/AIDS. Also needed in rural Native communities is transportation to services and, in particular, access to medical transportation.

Outreach. There is a need for culturally specific communication and media strategies to increase awareness, communicate information, and share positive stories from people living with HIV/AIDS. Strategies to promote health care services are also needed. Some strategies discussed include implementing universal screening, holding HIV/AIDS testing events, and using HIV rapid test kits. Participants also felt that people would benefit from less wait time between medical appointments and targeted outreach on reservations. Lastly, because of the associated stigma, it's important for HIV services to be marketed confidentially and not being targeted towards people in a way that would indicate that they have a positive status.

Additional needs*.* As mentioned previously, there is a need for accurate data. The fidelity with which the data is being collected and reported to the state is of concern. There is also a need for more funding options that are better publicized and available at the local level. One group said there is a need for funding for a teen clinic. Another group said there is a need for involving people with lived experience in coming up with solutions to ending HIV/AIDS in the Native American community and that there needs to be more work across systems in collaboration to address core issues that prevent people from seeking and staying in treatment.

Barriers to ending HIV/AIDS in Native American communities

Talking circle participants identified the key barriers Native American communities are facing to address HIV/AIDS as inadequate health care services and funding/resources.

Inadequate health care services*.* Participants shared that key barriers to addressing HIV/AIDS in their communities included frequent provider turnover and a lack of cultural competence among providers. There is also a lack of providers who belong to the LGBTQ community, which is a hindrance for some who would like to seek health care services, but do not feel comfortable because they don't have a provider they feel can relate to them.

Inadequate funding/resources*.* Participants said that there is a lack of funding due to low numbers of those infected with HIV/AIDS in Native American communities and that resources that do exist are largely for testing rather than treatment. Specifically, it was noted that Indian Health Services (IHS) is underfunded and that decisions about funding are made at the federal level, rather than the tribal level. In general there is not enough time nor resources allocated to the topic of HIV/AIDS in Native American communities.

Additional barriers*.* One group discussed that there may be issues of affordability for those without health insurance. Other barriers include transportation or distance to access HIV health care, and homelessness. Challenges also exist with treatment requirements (e.g., patients must be 'clean' to start anti-retroviral drugs). Other barriers include lack of trust in IHS, marginalization (people feeling like there's nowhere to turn), lack of knowledge among the general population about HIV/AIDs, and language barriers.

Ways state agencies can support existing or future efforts to end HIV/AIDS in the Native American community

When discussing how state agencies can support efforts to end HIV/AIDS in Native American communities, participants mentioned that, in general, there needs to be more dedication and commitment from state government on the topic of HIV/AIDS in Native American communities. Additionally, they commonly spoke about 1) changing available funding and resources, 2) collaboration with other state agencies and with smaller organizations, and 3) improving sex education.

Funding and resources. Participants indicated that the state should provide more funding in general and also work to maximize available resources. Specific funding needs included funding for a teen clinic, day care services for women with children, and disposable needle drop boxes (in public bathrooms, government centers, parks). There is also a need for support for newer and smaller organizations. Specifically, grant applications should be easier and more accessible to people without grant writing experience. Tribal nations could also use help leveraging national funds, such as from the Substance Abuse and Mental Health Services Administration (SAMHSA), for harm reduction and syringe exchange in addition to treatment and overdose prevention. One participant said, “MDH/DHS must support payment for treatment.”

Collaboration. Participants said that more collaboration between state agencies, and with tribes, in general would be beneficial to efforts in tribal nations around HIV/AIDS. It was specifically noted that the State could be instrumental in assisting tribes to identify how HIV testing data is being collected in clinics on reservations. Additionally, one group thought it would be supportive to have state agencies willing to partner and collaborate with smaller organizations.

Education. There is a need for support in improving sex education to be more comprehensive and to increase condom availability.

Next steps

In 2019, DHS and MDH will continue to gather input from individual Native American communities across Minnesota, including the metro area, to better understand the issues and needs they experience in relation to HIV/AIDS, as well as the barriers they face to ending HIV/AIDS. This process will also include gathering additional input on how state agencies can support efforts to address HIV/AIDS in Native American communities.